ARC 3682C

INSURANCE DIVISION[191]

Adopted and Filed

Rule making related to organized delivery systems

The Insurance Division hereby amends Chapter 4, "Agency Procedure for Rule Making and Waiver of Rules," Chapter 35, "Accident and Health Insurance," Chapter 37, "Medicare Supplement Insurance," Chapter 41, "Limited Service Organizations," Chapter 71, "Small Group Health Benefit Plans," Chapter 73, "Health Insurance Purchasing Cooperatives," Chapter 74, "Health Care Access," Chapter 75, "Iowa Individual Health Benefit Plans," and Chapter 78, "Uniform Prescription Drug Information Card," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 505.8.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapters 505, 507B, 509, 509A, 513B, 513C, 514A, 514B, 514C, 514E, 514F, 514I, 514J, 514K, 514L, and 521F as amended by 2017 Iowa Acts, House File 393, sections 29 to 103.

Purpose and Summary

The purpose of these amendments is to implement 2017 Iowa Acts, House File 393, sections 29 to 103, by removing references to "organized delivery systems" from the Insurance Division's rules.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on January 17, 2018, as **ARC 3571C**. No public comments were received. Some technical changes from the Notice have been made for clarification.

Adoption of Rule Making

This rule making was adopted by the Iowa Insurance Commissioner on February 22, 2018.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

The Insurance Division's general waiver provisions of 191—Chapter 4 apply to these rules.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on April 18, 2018.

The following rule-making actions are adopted:

ITEM 1. Amend paragraph **4.24(2)"a"** as follows:

a. For purposes of Iowa Code chapter 505B and this subrule, the following definitions shall apply:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Intended recipient" means the person to whom notice is required to be delivered, including but not limited to notices listed in the definition of "notice of cancellation, nonrenewal or termination" in this paragraph and in 191—paragraphs 20.80(1)*"b,"* 30.9(1)*"b,"* 35.9(1)*"b,"* 39.33(1)*"b,"* and 40.26(1)*"b."*

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code chapters 505B, 508, 509B, 513B, 514, 514B, 514D, 514G, 515, 515D, 518, 518A and 519, "notice of cancellation, nonrenewal or termination" includes but is not limited to the following:

- An insurance company's notice of cancellation, nonrenewal, suspension, exclusion, intention not to renew, failure to renew, termination, replacement, rescission, forfeiture or lapse in an annuity policy, a life insurance policy, a long-term care insurance policy, or an insurance policy other than life;
- An insurance company's rescission or discontinuance of an accident and health insurance policy;
- An insurance company's notice of cancellation of personal lines policies or contracts;
- A health maintenance organization's notice to an enrollee of cancellation or rescission of membership;
- An employer's or group policyholder's notice to an employee or member of the termination or substantial modification of the continuation of an employer group accident or health policy; or
- A carrier's ~~or organized delivery system's~~ advance notice to affected small employers, participants, and beneficiaries of its decision to discontinue offering a particular type of health insurance coverage.

ITEM 2. Amend paragraph **4.24(2)"b"** as follows:

b. This subrule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance in Iowa, health maintenance organizations, employers, group policyholders, or carriers ~~and organized delivery systems~~ and to all requirements by statute or rule related to notices of cancellation, nonrenewal or termination. This subrule shall apply when an insurance company, health maintenance organization, employer, group policyholder, or carrier ~~or organized delivery system~~ seeks the commissioner's approval of a manner for delivering by electronic means required notices of cancellation, nonrenewal or termination, as described in Iowa Code section 505B.1.

ITEM 3. Amend subrule 35.3(3), introductory paragraph, as follows:

35.3(3) For purposes of ~~2005 Iowa Acts, House File 420, section 1,~~ Iowa Code section 514C.22 relating to biologically based mental illness coverage in a group policy, contract or plan providing for third-party payment of health, medical, and surgical coverage benefits issued by a carrier ~~or by an organized delivery system~~, "biologically based mental illness" shall mean the following mental disorders as they are defined under the following diagnostic classes within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, edition DSM-IV-TR:

ITEM 4. Amend rule 191—35.9(509B,513B,514D) as follows:

191—35.9(509B,513B,514D) Notice of cancellation, nonrenewal or termination of accident and health insurance.

35.9(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer, issuer, employer, group policyholder, or carrier ~~or organized delivery system~~, so as to implement the various policyholder protections intended by Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A and chapter 505B.

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. and 2. No change.

3. For purposes of notices required by Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A and chapter 505B, "notice of cancellation, nonrenewal or termination" includes but is not limited to the following:

- An employer's or group policyholder's notification to employees or members of the termination or substantial modification of the continuation of an employer group accident or health policy pursuant to Iowa Code section 509B.5;
- A carrier's ~~or organized delivery system's~~ advance notice to all affected small employers, participants, and beneficiaries of its decision to discontinue offering a particular type of small group health insurance plan pursuant to Iowa Code section 513B.5(1)*"e"*(2);
- An insurance company's notice of termination of an individual accident and sickness policy, pursuant to rules promulgated pursuant to Iowa Code section 514D.3;
- An insurance company's notice of forfeiture, suspension, cancellation, or intention not to renew, pursuant to Iowa Code section 515.125; or
- An insurance company's notice of cancellation of personal lines policies or contracts pursuant to Iowa Code section 515.129A.

35.9(2) No change.

35.9(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by an insurer, employer, group policyholder, or carrier ~~or organized delivery system~~ to be effective, an insurer, employer, group policyholder, or carrier ~~or organized delivery system~~ must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in the Iowa Code sections cited in this subrule for certified mail or certificate of mailing as proof of mailing.

35.9(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 35.9(3), if an insurer, issuer, employer, group policyholder, or carrier ~~or organized delivery system~~ receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A and chapter 505B.

This rule is intended to implement Iowa Code chapters 505B, 509B, 513B, 514D, and 515.

ITEM 5. Amend rule **191—35.23(509)**, definition of "Creditable coverage," as follows:

"Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.
4. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under Section 1928 of that Act.
5. 10 U.S.C. ch. 55.

6. A health or medical care program provided through the Indian Health Service or a tribal organization.

7. A state health benefits risk pool.

8. A health plan offered under 5 U.S.C. ch. 89.

9. A public health plan as defined under federal regulations.

10. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

~~11. An organized delivery system licensed by the director of public health.~~

~~12.~~ 11. A short-term limited durational policy.

ITEM 6. Rescind the definition of "Organized delivery system" in rule **191—35.23(509)**.

ITEM 7. Amend rule 191—35.24(509) as follows:

191—35.24(509) Eligibility to enroll.

35.24(1) A carrier ~~or an organized delivery system~~ offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. to *h.* No change.

35.24(2) and **35.24(3)** No change.

35.24(4) A carrier ~~or organized delivery system~~ offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage. This subrule shall not be construed to do either of the following:

a. No change.

b. Prevent a carrier ~~or organized delivery system~~ offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

35.24(5) A carrier ~~or organized delivery system~~ shall not modify a health insurance coverage with respect to an employer or any eligible employee or dependent through riders, endorsements or other means, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the health insurance coverage.

ITEM 8. Amend subrule 35.25(1) as follows:

35.25(1) A carrier ~~or organized delivery system~~ shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health insurance coverage, if an eligible employee requests enrollment or, if the group health insurance coverage makes coverage available to dependents, on behalf of a dependent who is eligible but not enrolled under the group health insurance coverage, during the special enrollment period, which shall be 30 days following an event described in ~~subrules~~ subrule 35.25(2) or 35.25(3) with respect to the individual for whom enrollment is requested. A carrier ~~or organized delivery system~~ may impose enrollment requirements that are otherwise applicable under terms of the group health insurance coverage to individuals requesting immediate enrollment.

ITEM 9. Amend rule 191—35.26(509) as follows:

191—35.26(509) Group health insurance coverage policy requirements.

35.26(1) Group health insurance coverage subject to the rules in this division is renewable with respect to all eligible employees or their dependents at the option of the employer, except for one or more of the following reasons:

a. and *b.* No change.

c. Noncompliance with the carrier's ~~or organized delivery system's~~ minimum participation requirements or employer contribution requirements.

d. No change.

e. A carrier ~~or ODS~~ may choose to discontinue offering and cease to renew a particular type of health insurance coverage in the large group market if the carrier does all of the following:

(1) and (2) No change.

(3) Offers to each plan sponsor of the discontinued coverage the option to purchase any other coverage currently offered by the carrier ~~or ODS~~ to other employers in this state.

(4) No change.

f. A decision by the carrier ~~or ODS~~ to discontinue offering and cease to renew all of its health insurance delivered or issued for delivery to employers in this state shall do all of the following:

(1) to (3) No change.

g. No change.

h. The commissioner or director finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's ~~or ODS's~~ ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier ~~or ODS~~ may modify the health insurance coverage for a product offered under group health insurance coverage in the group market, if such modification is consistent with the laws of this state and is effective on a uniform basis among group health insurance coverage with that product.

35.26(2) A carrier ~~or ODS~~ that elects not to renew health insurance coverage under 35.26(1) *"f"* shall not write any new business in the group market in this state for a period of five years after the date of notice to the commissioner or director.

35.26(3) This rule applies only to a carrier ~~or ODS~~ doing business in one established geographic service area of the state and the carrier's ~~or ODS's~~ operations in that service area.

35.26(4) Preexisting condition exclusions.

a. A carrier ~~or ODS~~, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) to (3) No change.

b. A carrier ~~or ODS~~ offering group health insurance coverage shall not impose any preexisting condition as follows:

(1) to (3) No change.

c. A carrier ~~or ODS~~ shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this paragraph, "affiliation period" means a period of time not to exceed 60 days for new entrants and not to exceed 90 days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors.

d. A group health ~~plan, carrier, or ODS~~ plan or carrier offering group health insurance under the plan may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant under rule 191—35.29(509).

ITEM 10. Amend rule 191—35.27(509) as follows:

191—35.27(509) Methods of counting creditable coverage.

~~35.27(1)~~ For purposes of reducing any preexisting condition exclusion period, a group health ~~plan, carrier, or ODS~~ plan or carrier offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in ~~paragraph 35.27(1) *"a,"*~~ subrule 35.27(1) except that the ~~plan, carrier or ODS~~ plan or carrier may use the alternative method under

~~paragraph 35.27(1)"b"~~ subrule 35.27(2) with respect to any or all of the categories of benefits described under ~~paragraph 35.27(1)"d."~~ subrule 35.27(4).

~~a.~~ **35.27(1)** Under the standard method, a group health ~~plan,~~ plan or health insurance ~~carrier, or an ODS~~ carrier offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

~~(1)~~ *a.* For purposes of reducing the preexisting condition exclusion period, a group health ~~plan,~~ plan or health insurance ~~carrier, or an ODS~~ carrier offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

~~(2)~~ *b.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

~~(3)~~ *c.* Notwithstanding any other provisions of ~~paragraph 35.27(1)"b,"~~ subrule 35.27(2) for purposes of reducing a preexisting condition exclusion period, a group health ~~plan,~~ plan or a health insurance ~~carrier, or an ODS~~ carrier offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in ~~paragraph 35.27(1)"b."~~ subrule 35.27(2).

~~b.~~ **35.27(2)** Under the alternative method, a group health ~~plan,~~ plan or a health insurance ~~carrier, or an ODS~~ carrier offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in ~~paragraph 35.27(1)"d"~~ subrule 35.27(4) and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of ~~paragraph 35.27(1)"a."~~ subrule 35.27(1).

~~c.~~ **35.27(3)** A ~~plan, carrier, or ODS~~ plan or carrier using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

~~d.~~ **35.27(4)** The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

~~(1)~~ *a.* Mental health.

~~(2)~~ *b.* Substance abuse treatment.

~~(3)~~ *c.* Prescription drugs.

~~(4)~~ *d.* Dental care.

~~(5)~~ *e.* Vision care.

~~e.~~ **35.27(5)** If the alternative method is used, the plan is required to:

~~(1)~~ *a.* State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan;

~~(2)~~ *b.* Include in these statements a description of the effect of using the alternative method, including an identification of the category's uses; and

~~(3)~~ *c.* Count creditable coverage within a category if any level of benefits is provided within the category.

ITEM 11. Amend rule 191—35.28(509) as follows:

191—35.28(509) Certificates of creditable coverage.

35.28(1) Group health ~~plans, carriers, or ODSs~~ plans or carriers shall issue certificates of creditable coverage to persons losing coverage. A group health ~~plan, carrier, or ODS~~ plan or carrier required to provide a certificate under this rule for an individual is deemed to have satisfied the certification

requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

a. to *c.* No change.

35.28(2) Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

a. No change.

b. The individual requests that the certificate be sent to another ~~plan, carrier, or ODS~~ plan or carrier;

c. The ~~plan, carrier, or ODS~~ plan or carrier receiving the certificate agrees to accept the information through means other than a written certificate;

d. No change.

35.28(3) and **35.28(4)** No change.

35.28(5) Dependent coverage transition rule. A group health ~~plan, carrier, or ODS~~ plan or carrier that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

35.28(6) Delivering certificates. The certificate shall be given to the individual, ~~plan, carrier, or ODS~~ plan or carrier requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

35.28(7) A group health ~~plan, carrier, or ODS~~ plan or carrier shall establish a procedure for individuals to request and receive certificates.

35.28(8) A certificate is not required to be furnished until the group health ~~plan, carrier, or ODS~~ plan or carrier knows or should have known that the dependent's coverage terminated.

35.28(9) Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health ~~plan, carrier, or ODS~~ plan or carrier shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

ITEM 12. Amend rule 191—35.29(509) as follows:

191—35.29(509) Notification requirements.

35.29(1) A group health ~~plan, carrier, or ODS~~ plan or carrier shall provide written notice to the employee and dependents that includes the following:

a. No change.

b. A determination that the group health ~~plan, carrier, or ODS~~ plan or carrier intends to impose a preexisting condition exclusion and:

(1) to (3) No change.

(4) The right of the person to demonstrate creditable coverage including the right of the person to request a certificate from a prior group health ~~plan, carrier, or ODS~~ plan or carrier and a statement that the current group health ~~plan, carrier, or ODS~~ plan or carrier will assist in obtaining the certificate.

c. and *d.* No change.

35.29(2) A group health ~~plan, carrier, or ODS~~ plan or carrier shall provide written notice to the employee and dependents of a modification of a prior creditable coverage decision when the group health ~~plan, carrier, or ODS~~ plan or carrier subsequently determines either no or less creditable coverage existed provided that the group health ~~plan, carrier, or ODS~~ plan or carrier acts according to its initial determination until the final determination is made.

ITEM 13. Amend rule 191—35.31(509) as follows:

191—35.31(509) Disclosure requirements. All carriers ~~and ODSs~~ shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all carriers ~~and ODSs~~ offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers ~~and ODSs~~ shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

ITEM 14. Amend rule 191—35.35(509) as follows:

191—35.35(509) Reconstructive surgery.

35.35(1) A carrier ~~or organized delivery system~~ that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. to *c.* No change.

35.35(2) and **35.35(3)** No change.

35.35(4) A carrier ~~or organized delivery system~~ shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier ~~or organized delivery system~~ shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

ITEM 15. Amend rule 191—35.39(514C) as follows:

191—35.39(514C) Contraceptive coverage.

35.39(1) A carrier ~~or organized delivery system~~ that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

35.39(2) A carrier ~~or organized delivery system~~ is not required to provide benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

35.39(3) No change.

35.39(4) A carrier ~~or organized delivery system~~ shall be required to provide benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

35.39(5) If a carrier ~~or organized delivery system~~ does not provide benefits for a routine physical examination, the carrier ~~or organized delivery system~~ is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement ~~2000 Iowa Acts, Senate File 2126~~ Iowa Code chapter 514C.

ITEM 16. Amend rule **191—37.3(514D)**, definition of "Creditable coverage," as follows:

"Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;

3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

5. Chapter 55 of Title 10, United States Code (CHAMPUS);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

9. A public health plan as defined in federal regulation; ~~and~~

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). ~~;~~ and

~~11. A organized delivery system.~~

~~12.~~ 11. Short-term limited durational policy.

"Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and

2. Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

3. Similar supplemental coverage provided to coverage under a group health plan.

ITEM 17. Amend rule **191—41.1(514B)**, definition of "Limited service organization (LSO)," as follows:

~~*"Limited service organization (LSO)"*~~ *"Limited service organization"* or *"LSO"* means any corporation or limited liability company or other entity which, in return for prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Entities authorized to do business pursuant to Iowa Code chapters 508, 512B, 514, 514B (health maintenance organizations), 515, and 520 ~~and organized delivery systems~~ shall not be required to obtain separate licensure as an LSO.

ITEM 18. Amend rule 191—71.1(513B) as follows:

191—71.1(513B) Purpose. This chapter is intended to implement the provisions of Iowa Code chapter 513B to provide for the guaranteed issue of all health insurance products in the small group market, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health insurance coverages; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of "basic" and "standard" health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; to improve the overall fairness and efficiency of the small group health insurance market and to promote broader spreading of risk in the small employer marketplace. Carriers ~~and ODSs~~ that provide basic and standard health benefit plans, as herein set forth, to small employers are intended to be subject to all provisions of Iowa Code chapter 513B and this chapter ~~of rules~~.

71.1(1) No change.

71.1(2) A carrier ~~or organized delivery system~~ subject to this chapter is required to guarantee issue small employer plans except for reasons set forth in Iowa Code chapter 513B.

ITEM 19. Amend rule **191—71.2(513B)**, definition of "Short-term limited duration insurance," as follows:

"Short-term limited duration insurance" means health insurance coverage provided under a contract with a carrier ~~or ODS~~ that has an expiration date specified in the contract, taking into account any extensions that may be elected by the policyholder without the carrier's ~~or ODS's~~ consent, that is, within 12 months of the date the contract becomes effective.

ITEM 20. Rescind the definition of "Organized delivery system" in rule **191—71.2(513B)**.

ITEM 21. Amend rule 191—71.3(513B) as follows:

191—71.3(513B) Applicability and scope.

71.3(1) *a.* and *b.* No change.

71.3(2) *a.* A carrier ~~or ODS~~ that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier ~~or ODS~~ and subject to the provisions of Iowa Code chapter 513B and this chapter with respect to such policies if the small employer contributes, directly or indirectly, to the premiums for the policies and the carrier ~~or ODS~~ is aware, or should have been aware, of such contribution.

b. In the case of a carrier ~~or ODS~~ that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered an eligible small employer as defined in Iowa Code section 513B.10 and the small employer carrier subject to Iowa Code section 513B.10(1)*"b"*(2) if:

(1) and (2) No change.

(3) The carrier ~~or ODS~~ is aware, or should have been aware, of the contribution by the employer.

71.3(3) No change.

71.3(4) An individual health insurance policy shall not be subject to Iowa Code chapter 513B and this chapter solely because the policyholder elects a business expense deduction under Section 162(1) of the Internal Revenue Code, the health insurance coverage is treated as part of a plan or program for purposes of Section 125 of the Internal Revenue Code for which the employee makes all the contributions, or the employer provides payroll deduction of health insurance premiums on behalf of an employee if the health insurance coverage covers employees where the employer has applied for group health benefits and has received written notification that the group did not meet the small group carrier's ~~or ODS's~~ minimum participation or contribution standards. The individual health insurance carrier ~~or ODS~~ shall maintain a copy of the employer's notification from the small group carrier for insurance division audit purposes.

71.3(5) *a.* If a small employer is issued health insurance coverage under the terms of Iowa Code chapter 513B, the provisions of Iowa Code chapter 513B and this chapter shall continue to apply to the

health insurance coverage in the case that the small employer subsequently employs more than 50 eligible employees. A carrier ~~or ODS~~ providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 50 eligible employees but no later than the anniversary date of the employer's health insurance coverage, notify the employer that the protections provided under Iowa Code chapter 513B and this chapter shall cease to apply to the employer if such employer fails to renew its current health insurance coverage or elects to enroll in different health insurance coverage. It is the responsibility of the employer to notify the carrier ~~or ODS~~ of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

b. (1) If health insurance coverage is issued to an employer that is not a small employer as defined, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of Iowa Code chapter 513B shall not apply to the health insurance coverage. The carrier ~~or ODS~~ providing health insurance coverage to such an employer shall not become a small employer carrier ~~or ODS~~ under the terms of Iowa Code chapter 513B solely because the carrier ~~or ODS~~ continues to provide coverage under the health insurance coverage to the employer.

(2) A carrier ~~or ODS~~ providing coverage to an employer described in subparagraph 71.3(5)*"b"*(1) shall, within 60 days of becoming aware that the employer has 50 or fewer eligible employees, notify the employer of the options and protections available to the employer under Iowa Code chapter 513B, including the employer's option to purchase a small employer health insurance coverage from any small employer carrier ~~or ODS~~. It is the responsibility of the employer to notify the carrier of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

71.3(6) *a.* (1) and (2) No change.

71.3(7) A carrier ~~or ODS~~ that is not operating as a small employer carrier ~~or ODS~~ in this state shall not become subject to the provisions of the Act and this regulation solely because a small employer that was issued health insurance coverage in another state by that carrier ~~or ODS~~ moves to this state.

ITEM 22. Amend rule 191—71.4(513B) as follows:

191—71.4(513B) Establishment of classes of business.

71.4(1) A small employer carrier ~~or ODS~~ that establishes more than one class of business as defined in Iowa Code section 513B.2 shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

a. to *c.* No change.

71.4(2) A carrier ~~or ODS~~ may not directly or indirectly use group size as a criterion for establishing eligibility for health insurance coverage or for a class of business.

ITEM 23. Amend rule 191—71.5(513B) as follows:

191—71.5(513B) Transition for assumptions of business from another carrier.

71.5(1) *a.* A small employer carrier ~~or ODS~~ shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless:

(1) The transaction has been approved by the commissioner of the state of domicile of the assuming carrier ~~or ODS~~;

(2) The transaction has been approved by the commissioner of the state of domicile of the ceding carrier ~~or ODS~~; and

(3) No change.

b. A carrier ~~or ODS~~ domiciled in this state that proposes to assume or cede the entire insurance obligation or risk of one or more small employer health benefit plans from another carrier ~~or ODS~~ shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health insurance coverages to be transferred and is consistent with the purposes of Iowa Code chapter 513B and this chapter. The commissioner shall not approve the transaction until at least 30 days after the date of the filing except that, if the ceding carrier

~~or ODS~~ is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems reasonable after the filing.

c. (1) The filing required under paragraph 71.5(1)*"b"* shall:

1. Describe the class of business (including any eligibility requirements) of the ceding carrier ~~or ODS~~ from which the health insurance coverage will be ceded;

2. Describe whether the assuming carrier ~~or ODS~~ will maintain the assumed health insurance coverage as a separate class of business (pursuant to 71.5(3)) or will incorporate them into an existing class of business (pursuant to 71.5(4)). If the assumed health insurance coverage will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier ~~or ODS~~ into which the health insurance coverages will be incorporated;

3. to 7. No change.

(2) A small employer carrier ~~or ODS~~ required to make a filing under 71.5(1)*"b"* shall also make an informational filing with the commissioner of each state in which there are small employer health insurance coverages that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under 71.5(1)*"b"* and shall include at least the information specified in 71.5(1)*"c"*(1) for the small employer health insurance coverages in that state.

d. A small employer carrier ~~or ODS~~ shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless it complies with the following provisions:

(1) The carrier ~~or ODS~~ has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in 71.5(1)*"c"* for the health insurance coverages covering small employers in this state.

(2) If the assumption of a class of business would result in the assuming small employer ~~carrier or ODS~~ carrier's being out of compliance with the limitations related to premium rates contained in Iowa Code section 513B.4(1)*"a,"* the assuming carrier ~~or ODS~~ shall make a filing with the commissioner pursuant to Iowa Code section 513B.17 seeking suspension of the application of Iowa Code section 513B.4(1)*"a."*

(3) An assuming carrier ~~or ODS~~ seeking suspension of the application of Iowa Code ~~paragraph~~ section 513B.4(1)*"a"* shall not complete the assumption of health insurance coverages covering small employers in this state unless the commissioner grants the suspension requested pursuant to 71.5(1)*"d"*(2).

(4) No change.

71.5(2) *a.* Except as provided in paragraph 71.5(1)*"b,"* a small employer carrier ~~or ODS~~ shall not cede or assume the entire insurance obligation or risk for small employer health insurance coverage unless the transaction includes ceding to the assuming carrier ~~or ODS~~ the entire class of business that includes such health insurance coverage.

b. A small employer carrier ~~or ODS~~ may cede less than an entire class of business to an assuming carrier if:

(1) One or more small employers in the class have exercised their right under contract or state law to reject (either directly or by implication) the ceding of their health insurance coverage to another carrier ~~or ODS~~. In that instance, the transaction shall include each health insurance coverage in the class of business except those health insurance coverages for which a small employer has rejected the proposed cession; or

(2) No change.

71.5(3) Except as provided in 71.5(4), a small employer carrier ~~or ODS~~ that assumes one or more health insurance coverages from another carrier ~~or ODS~~ shall maintain such health insurance coverages as a separate class of business.

71.5(4) A small employer carrier ~~or ODS~~ that assumes one or more health insurance coverages from another carrier ~~or ODS~~ may exceed the limitation contained in Iowa Code section 513B.2 (relating to the maximum number of classes of business a carrier ~~or ODS~~ may establish) due solely to such assumption for a period of up to 15 months after the date of the assumption, provided that the carrier ~~or ODS~~ complies with the following provisions:

a. Upon assumption of the health insurance coverages, such health insurance coverages shall be maintained as a separate class of business. During the 15-month period following the assumption, each of the assumed small employer health insurance coverages shall be transferred by the assuming small employer carrier ~~or ODS~~ into a single class of business operated by the assuming small employer carrier ~~or ODS~~. The assuming small employer carrier ~~or ODS~~ shall select the class of business into which the assumed health insurance coverages will be transferred in a manner that results in the least possible change to the coverages and rating method of the assumed health insurance coverages.

b. No change.

c. A small employer carrier ~~or ODS~~ making a transfer pursuant to paragraph *"a"* may alter the benefits of the assumed health insurance coverages to conform to the benefits currently offered by the carrier in the class of business into which the health insurance coverages have been transferred.

d. The premium rate for an assumed small employer health insurance coverage shall not be modified by the assuming small employer carrier ~~or ODS~~ until the health insurance coverage is transferred pursuant to paragraph *"a."* Upon transfer, the assuming small employer carrier ~~or ODS~~ shall calculate a new premium rate for the health insurance coverage from the rate manual established for the class of business into which the health insurance coverage is transferred. In making such calculation, the risk load applied to the health insurance coverage shall be no higher than the risk load applicable to such health insurance coverage prior to the assumption.

e. No change.

71.5(5) An assuming carrier ~~or ODS~~ may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health insurance coverage (or with respect to any health insurance coverage subsequently offered to a small employer covered by such an assumed health insurance coverage) that are more stringent than the requirements applicable to such health insurance coverage prior to the assumption.

71.5(6) The commissioner may approve a longer period of transition upon application of a small employer carrier ~~or ODS~~. The application shall be made within 60 days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

71.5(7) Nothing in this rule or in Iowa Code chapter 513B is intended to:

a. Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier ~~or ODS~~ related to the transaction;

b. Authorize a carrier ~~or ODS~~ that is not admitted to transact the business of insurance in this state to offer health insurance coverages in this state; or

c. No change.

ITEM 24. Amend rule 191—71.6(513B) as follows:

191—71.6(513B) Restrictions relating to premium rates.

71.6(1) *a.* A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this rule. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

b. (1) and (2) No change.

(3) For the purpose of this rule, a change in rating method shall mean:

1. A change in the number of case characteristics used by a small employer carrier ~~or ODS~~ to determine premium rates for health insurance coverages in a class of business;

2. to 4. No change.

For the purpose of ~~subparagraph (3), paragraph "1" above,~~ 71.6(1)*"b"*(3)"1," a change in a rating factor shall mean the cumulative change, with respect to such factor, considered over a 12-month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12-month period, the carrier shall consider the cumulative effect of all such changes in applying the 10

percent test under paragraph ~~"1."~~ 71.6(1)*"b"*(3)"1." A filing which has not previously been approved, denied, or questioned is deemed approved on or after 30 days from receipt by the division.

71.6(2) *a.* The rate manual developed pursuant to 71.6(1) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

b. No change.

c. A small employer carrier ~~or ODS~~ shall use the same case characteristics in establishing premium rates for each health insurance coverage in a class of business and shall apply them in the same manner in establishing premium rates for each health insurance coverage. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

d. No change.

e. Differences among base premium rates for health insurance coverages shall be based solely on the reasonable and objective differences in the design and benefits of the health insurance coverages and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage. A small employer carrier ~~or ODS~~ shall apply case characteristics and rate factors within a class of business in a manner that ensures that premium differences among health insurance coverages for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health insurance coverages and are not due to the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage.

f. No change.

g. (1) No change.

(2) A carrier ~~or ODS~~ may charge a separate fee with respect to a health insurance coverage (but only one fee with respect to such plan) provided the fee is no more than $5 per month per employee and is applied in a uniform manner to each health insurance coverage in a class of business.

h. A small employer carrier ~~or ODS~~ shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable a basis than expenses are allocated to other health insurance coverages in the class of business. The rate manual developed pursuant to 71.6(1) shall describe the method of allocating administrative expenses to the health insurance coverages in the class of business for which the manual was developed.

i. and *j.* No change.

71.6(3) No change.

71.6(4) The restrictions related to changes in premium rates in Iowa Code sections 513B.4(1)*"c"* and 513B.4(1)*"d"* shall be applied as follows:

a. No change.

b. (1) No change.

(2) If, for any health insurance coverages with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health insurance coverage shall be considered health insurance coverage into which the small employer carrier ~~or ODS~~ is no longer enrolling new small employers for the purposes of Iowa Code sections 513B.4(1)*"c"* and 513B.4(1)*"d."*

c. If, for any rating period, the change in the new business premium rate for health insurance coverage differs from the change in the new business premium rate for any other health insurance coverage in the same class of business by more than 20 percent, the carrier ~~or ODS~~ shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within 30 days of the beginning of the rating period.

d. A small employer carrier ~~or ODS~~ shall keep on file, for a period of at least six years, the calculations used to determine the change in base premium rates and new business premium rates for each health insurance coverage for each rating period.

71.6(5) *a.* Except as provided in paragraphs *"b"* through *"d,"* a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) and (2) No change.

b. In the case of health insurance coverage into which a small employer carrier ~~or ODS~~ is no longer enrolling new small employers, a change in a premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) No change.

(2) One plus the lesser of:

1. No change.

2. The percentage change in the new business premium for the most similar health insurance coverage into which the small employer carrier ~~or ODS~~ is enrolling new small employers, multiplied by

(3) No change.

c. and *d.* No change.

71.6(6) *a.* A representative of a Taft Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the commissioner a request for the waiver of application of the provisions of Iowa Code section 513B.4 with respect to such trust.

b. A request made under paragraph *"a"* shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provisions would:

(1) Adversely affect the participants and beneficiaries of the trust; and

(2) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

c. A waiver granted under Iowa Code section 513B.4A shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.

ITEM 25. Amend rule 191—71.7(513B) as follows:

191—71.7(513B) Requirement to insure entire groups.

71.7(1) *a.* A small employer carrier ~~or ODS~~ that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. The small employer carrier ~~or ODS~~ shall provide the same health insurance coverage to each employee and dependent.

b. No change.

71.7(2) *a.* Except as provided in this subrule, a small employer carrier ~~or ODS~~ may not issue health insurance coverage to a small employer unless the health insurance coverage covers all eligible employees and all dependents of eligible employees.

b. A small employer carrier ~~or ODS~~ may issue health insurance coverage to a small employer that excludes an eligible employee or the dependent of an eligible employee only if:

(1) to (3) No change.

c. A small employer carrier ~~or ODS~~ shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees. The small employer carrier ~~or ODS~~ shall require the small employer to provide appropriate supporting documentation in the form of a W-2 Summary Wage and Tax Form and federal or state quarterly withholding statements for the current year and the year immediately preceding the year of application for coverage.

(1) A small employer carrier ~~or ODS~~ shall secure a waiver, with respect to each eligible employee and each dependent of an eligible employee, declining an offer of coverage under health insurance coverage provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health insurance coverage. The waiver form shall require that the reason for declining coverage ~~is~~ be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier ~~or ODS~~ for a period of six years.

(2) A small employer carrier ~~or ODS~~ shall obtain, with respect to each individual who submits a waiver under 71.7(2)*"c"*(1), information sufficient to establish that the waiver is permitted under 71.7(2)*"b."*

d. (1) A small employer carrier ~~or ODS~~ shall not issue coverage to a small employer if the carrier is unable to obtain the list required under 71.7(2)*"c,"* a waiver required under 71.7(2*)"c"*(1) or the information required under 71.7(2)*"c"*(2) in circumstances set forth in this subrule.

(2) 1. A small employer carrier ~~or ODS~~ shall not offer coverage to a small employer if the carrier ~~or ODS~~, or a producer for such carrier ~~or ODS~~, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

2. A producer shall notify a small employer carrier ~~or ODS~~, prior to submitting an application for coverage with the carrier ~~or ODS~~ on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

71.7(3) *a.* New entrants to a small employer group shall be offered an opportunity to enroll in the health insurance coverage currently held by such group. A new entrant ~~that~~ who does not exercise the opportunity to enroll in the health insurance coverage within the period provided by the small employer carrier ~~or ODS~~ may be treated as a late enrollee by the carrier ~~or ODS~~, provided that the period provided to enroll in the health insurance coverage extends at least 30 days after the date the new entrant is notified of the opportunity to enroll. If a small employer carrier ~~or ODS~~ has offered more than one health insurance coverage to a small employer group pursuant to 71.7(1)*"b,"* the new entrant shall be offered the same choice of health insurance coverages as the other members of the group.

b. A small employer carrier ~~or ODS~~ shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with Iowa Code section 513B.10(4)), with respect to a new entrant that is longer than 60 days. This subrule does not affect an employer's ability to determine an employee's probationary period of work prior to the commencement of benefits.

c. New entrants to a group shall be accepted for coverage by the small employer carrier ~~or ODS~~ without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents except that a carrier may exclude coverage for preexisting medical conditions consistent with the provisions provided in Iowa Code section 513B.10.

d. A small employer carrier ~~or ODS~~ may assess a risk load to the premium rate associated with a new entrant consistent with the requirements of Iowa Code section 513B.4. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

71.7(4) *a.* Opportunity to enroll.

(1) In the case of an eligible employee (or dependent of an eligible employee) who, prior to July 1, 1993, was excluded from coverage or denied coverage by a small employer carrier ~~or ODS~~ in the process of providing health insurance coverage to an eligible small employer (as defined in Iowa Code section 513B.2(16)), the small employer carrier ~~or ODS~~ shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in health insurance coverage currently held by the small employer.

(2) A small employer carrier ~~or ODS~~ may require an individual who requests enrollment under this subrule to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual.

b. The opportunity to enroll shall meet the following requirements:

b. (1) The opportunity to enroll shall begin October 1, 1993, and extend for a period of at least three months.

(2) and (3) No change.

(4) A small employer carrier ~~or ODS~~ shall provide written notice at least 45 days prior to the opportunity to enroll provided in 71.7(4)*"a"*(1) to each small employer insured under health insurance coverage offered by such carrier ~~or ODS~~. The notice shall clearly describe the rights granted under

this subrule to employees and dependents previously excluded or denied coverage and the process for enrollment of such individuals in the employer's health insurance coverage.

ITEM 26. Amend rule 191—71.9(513B) as follows:

191—71.9(513B) Application to reenter state.

71.9(1) A carrier ~~or ODS~~ prohibited from writing coverage for small employers in this state pursuant to Iowa Code section 513B.5(2) may not resume offering health insurance coverage to small employers in this state until the carrier ~~or ODS~~ has made a petition to the commissioner or director to be reinstated as a small employer carrier ~~or ODS~~ and the petition has been approved by the commissioner or director. In reviewing a petition, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

71.9(2) In the case of a small employer carrier ~~or ODS~~ doing business in only one established geographic service area of the state, if the small employer carrier ~~or ODS~~ elects to nonrenew health insurance coverage under Iowa Code section 513B.5, the small employer carrier ~~or ODS~~ shall be prohibited from offering health insurance coverages to small employers in any other geographic area of the state without the prior approval of the commissioner or director. In considering whether to grant approval, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

ITEM 27. Amend rule 191—71.11(513B) as follows:

191—71.11(513B) Rules related to fair marketing.

71.11(1) *a.* A small employer carrier ~~or ODS~~ shall actively market health insurance coverages including one basic and one standard health benefit plan to small employers in this state. A small employer carrier ~~or ODS~~ may not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier ~~or ODS~~ has good cause and has received the prior approval of the commissioner or director.

b. In marketing the basic and standard health benefit plans to small employers, a small employer carrier ~~or ODS~~ shall use at least the same sources and methods of distribution that it uses to market other health insurance coverages to small employers.

71.11(2) *a.* A small employer carrier ~~or ODS~~, in accordance with the provisions of Iowa Code section 513B.10, shall accept every small employer that applies for health insurance coverage from the small employer carrier ~~or ODS~~ and shall accept every eligible individual who applies for enrollment. The offer shall be in writing and shall include at least the following information:

(1) and (2) No change.

b. (1) A small employer carrier ~~or ODS~~ shall provide a price quote to a small employer (directly or through an authorized producer) within ten working days of receiving a request for a quote and other information as necessary to provide the quote. A small employer carrier ~~or ODS~~ shall notify a small employer (directly or through an authorized producer) of any additional information needed by the small employer carrier ~~or ODS~~ to provide the quote within five working days of receiving a request for a price quote.

(2) A small employer carrier ~~or ODS~~ shall not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than applied for other health insurance coverage offered by the carrier ~~or ODS~~.

~~*c.* Rescinded IAB 7/16/97, effective 7/1/97.~~

71.11(3) A small employer carrier ~~or ODS~~ shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health insurance coverages in this state. The service shall provide information to callers regarding application for coverage from the carrier ~~or ODS~~. The information may include the names and telephone numbers of producers located in geographic proximity to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

71.11(4) The small group carrier ~~or ODS~~ shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier ~~or ODS~~ except, if membership in an association or other group is a requirement for accepting a small employer into health insurance coverage, a small employer carrier ~~or ODS~~ may apply such requirement.

71.11(5) A small employer carrier ~~or ODS~~ may not require, as a condition to the offer or sale of health insurance coverage to a small employer, that the small employer purchase or qualify for any other insurance product or service.

71.11(6) *a.* Carriers offering individual and group health insurance coverages in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513B and this chapter. Carriers ~~or ODSs~~ shall elicit the following information from applicants for such plans at the time of application:

(1) and (2) No change.

b. If a small employer carrier ~~or ODS~~ fails to comply with paragraph *"a,"* the small employer carrier ~~or ODS~~ shall be deemed on notice regarding any information that could reasonably have been attained if the small employer carrier had complied with paragraph *"a."*

71.11(7) *a.* A small employer carrier ~~or ODS~~ shall annually file the following information with the commissioner related to health insurance coverages issued by the small employer carrier ~~or ODS~~ to small employers in this state:

(1) to (6) No change.

b. No change.

71.11(8) and **71.11(9)** No change.

ITEM 28. Amend rule 191—71.12(513B) as follows:

191—71.12(513B) Status of carriers as small employer carriers.

71.12(1) Subject to 71.12(2), a carrier ~~or ODS~~ shall not offer health insurance coverages to small employers or continue to provide coverage under health insurance coverages previously issued to small employers in this state unless the carrier ~~or ODS~~ has made a filing with the commissioner or director that the carrier ~~or ODS~~ intends to operate as a small employer carrier ~~or ODS~~ in this state under the terms of this chapter.

71.12(2) *a.* If a carrier ~~or ODS~~ does not intend to operate as a small employer carrier ~~or ODS~~ in this state, the carrier ~~or ODS~~ may continue to provide coverage under health insurance coverages previously issued to small employers in this state only if the carrier ~~or ODS~~ complies with the following provisions:

(1) The carrier ~~or ODS~~ complies with the requirements of Iowa Code chapter 513B (other than Iowa Code sections 513B.11 to 513B.13) with respect to each of the health insurance coverages previously issued to small employers by the carrier ~~or ODS~~.

(2) The carrier ~~or ODS~~ provides coverage to each new entrant to health insurance coverage previously issued to a small employer by the carrier ~~or ODS~~. The provisions of Iowa Code chapter 513B (other than Iowa Code sections 513B.11 to 513B.13) and this chapter shall apply to the coverage issued new entrants.

(3) The carrier ~~or ODS~~ complies with the requirements of Iowa Code section 513B.17A, and rule 191—71.13(513B), as they apply to small employers whose coverage has been terminated by the carrier ~~or ODS~~, and to individuals and small employers whose coverage has been limited or restricted by the carrier ~~or ODS~~.

b. A carrier ~~or ODS~~ that continues to provide coverage pursuant to this subrule shall not be eligible to participate in the reinsurance program established under Iowa Code section 513B.11.

71.12(3) No change.

ITEM 29. Amend rule 191—71.13(513B) as follows:

191—71.13(513B) Restoration of coverage.

71.13(1) *a.* Except as provided in 71.13(1)*"b,"* a small employer carrier ~~or ODS~~ shall, as a condition of continuing to transact business in this state with small employers, offer to provide health insurance

coverage as described in 71.13(3) to any small employer carrier ~~or ODS~~ after January 1, 1993, unless the carrier's ~~or ODS's~~ termination is pursuant to Iowa Code section 513B.5.

b. No change.

71.13(2) No change.

71.13(3) A health insurance coverage provided to a terminated small employer pursuant to 71.13(1) shall meet the following conditions:

a. to *c.* No change.

d. The health insurance coverage shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier ~~or ODS~~ shall offer coverage to each dependent of such eligible employees.

e. The premium rate for the health insurance coverage shall be no more than the premium rate charged to the small employer on the date the health insurance coverage was terminated or nonrenewed provided that, if the number or case characteristics of the eligible employees (or their dependents) of the small employer has changed between the date the health insurance coverage was terminated or nonrenewed and the date that it is restored, the carrier ~~or ODS~~ may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier ~~or ODS~~ has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may be further adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health insurance coverage may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date the health insurance coverage is restored. Any such increase shall be subject to the provisions of Iowa Code section 513B.4.

f. The health insurance coverage shall not be eligible to be reinsured under the provisions of Iowa Code section 513B.12, except that the carrier ~~or ODS~~ may reinsure new entrants to the health insurance coverage who enroll after the restoration of coverage.

ITEM 30. Amend rule 191—71.15(513B) as follows:

191—71.15(513B) Methods of counting creditable coverage.

71.15(1) For purposes of reducing any preexisting condition exclusion period, a group health ~~plan, a carrier, or ODS~~ plan or a carrier offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in subrule 71.15(2), except that the ~~plan, carrier, or ODS~~ plan or carrier may use the alternative method under subrule 71.15(3) with respect to any or all of the categories of benefits described under paragraph 71.15(3)*"b."*

71.15(2) Under the standard method, a group health ~~plan,~~ plan and a health insurance ~~carrier, and an ODS~~ carrier offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

a. For purposes of reducing the preexisting condition exclusion period, a group health ~~plan,~~ plan or a health insurance ~~carrier, or ODS~~ carrier offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

b. No change.

c. Notwithstanding any other provision of paragraph 71.15(2)*"b,"* for purposes of reducing a preexisting condition exclusion period, a group health ~~plan,~~ plan and a health insurance ~~carrier, and an ODS~~ carrier offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in paragraph 71.15(2)*"b."*

71.15(3) Under the alternative method, a group health ~~plan,~~ plan or a health insurance ~~carrier, or an ODS~~ carrier offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in subparagraph 71.15(3)*"b"*(2) and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are

not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph 71.15(3)*"a."*

a. A ~~plan, carrier, or ODS~~ plan or carrier using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

b. No change.

c. If the alternative method is used, the plan is required to:

(1) and (2) No change.

(3) Under the alternative method, the group health ~~plan, carrier, or ODS~~ plan or carrier counts creditable coverage within a category if any level of benefits is provided within the category.

ITEM 31. Amend rule 191—71.16(513B) as follows:

191—71.16(513B) Certificates of creditable coverage.

71.16(1) Group health ~~plans, carriers, and ODSs~~ plans or carriers shall issue certificates of creditable coverage to persons losing coverage. A group health ~~plan, carrier, or ODS~~ plan or carrier required to provide a certificate under this rule for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

a. to *c.* No change.

71.16(2) Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

a. No change.

b. The individual requests that the certificate be sent to another plan or carrier ~~or ODS~~;

c. The ~~plan, carrier, or ODS~~ plan or carrier receiving the certificate agrees to accept the information through means other than a written certificate;

d. The ~~plan, carrier, or ODS~~ plan or carrier receiving the certificate receives the certificate within a reasonable amount of time.

71.16(3) and **71.16(4)** No change.

71.16(5) Dependent coverage transition rule. A group health plan or carrier ~~or ODS~~ that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

71.16(6) Delivering certificates. The certificate shall be given to the individual, plan or carrier ~~or ODS~~ requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

71.16(7) A group health ~~plan, carrier, or ODS~~ plan or carrier shall establish a procedure for individuals to request and receive certificates.

71.16(8) A certificate is not required to be furnished until the group health ~~plan, carrier, or ODS~~ plan or carrier knows or should have known that dependent's coverage terminated.

71.16(9) Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health ~~plan, carrier, or ODS~~ plan or carrier shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

ITEM 32. Amend rule 191—71.17(513B) as follows:

191—71.17(513B) Notification requirements.

71.17(1) A group health ~~plan, carrier, or ODS~~ plan or carrier shall provide written notice to the employee and dependents of:

a. The existence of any preexisting condition exclusions.

b. The length of time to which the exclusions will apply.

c. The right of the employee or dependent to appeal a decision to impose a preexisting condition exclusion.

d. The right of the person to demonstrate creditable coverage including:

(1) The right of the person to request a certificate from a prior group health ~~plan, carrier, or ODS~~ plan or carrier;

(2) A statement that the current group health ~~plan, carrier, or ODS~~ plan or carrier will assist in obtaining the certificate;

(3) That the group health ~~plan, carrier, or ODS~~ plan or carrier will use the alternative method of counting creditable coverage; and

(4) No change.

71.17(2) A group health ~~plan, carrier, or ODS~~ plan or carrier shall provide written notice to the employee and dependents of the modification of a prior creditable coverage decision when the group health ~~plan, carrier, or ODS~~ plan or carrier subsequently determines either no or less creditable coverage existed provided that the group health ~~plan, carrier, or ODS~~ plan or carrier acts according to its initial determination until the final determination is made.

ITEM 33. Amend rule 191—71.18(513B) as follows:

191—71.18(513B) Special enrollments.

71.18(1) A carrier ~~or organized delivery system~~ shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health plan, if an eligible employee requests enrollment or, if the group health plan makes coverage available to dependents, on behalf of a dependent who is eligible but not enrolled under the group health plan, during the special enrollment period, which shall be 30 days following an event described in subrules 71.18(2) and 71.18(3) with respect to the individual for whom enrollment is requested. A carrier ~~or organized delivery system~~ may impose enrollment requirements that are otherwise applicable under terms of the group health plan to individuals requesting immediate enrollment.

71.18(2) to **71.18(4)** No change.

ITEM 34. Amend rule 191—71.19(513B) as follows:

191—71.19(513B) Disclosure requirements. All carriers ~~and ODSs~~ shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier ~~or ODS~~ offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers ~~and ODSs~~ shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

ITEM 35. Amend rule 191—71.21(514C) as follows:

191—71.21(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall

be readily available at all times to render such services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

71.21(1) and **71.21(2)** No change.

71.21(3) Reimbursement to a provider of "emergency services" shall not be denied by any carrier ~~or ODS~~ without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

ITEM 36. Amend rule 191—71.23(513B) as follows:

191—71.23(513B) Reconstructive surgery.

71.23(1) A carrier ~~or organized delivery system~~ that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. to *c.* No change.

71.23(2) and **71.23(3)** No change.

71.23(4) A carrier ~~or organized delivery system~~ shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier ~~or organized delivery system~~ shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

ITEM 37. Amend rule 191—71.24(514C) as follows:

191—71.24(514C) Contraceptive coverage.

71.24(1) A carrier ~~or organized delivery system~~ that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

71.24(2) A carrier ~~or organized delivery system~~ is not required to provide benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

71.24(3) No change.

71.24(4) A carrier ~~or organized delivery system~~ shall be required to provide benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

71.24(5) If a carrier ~~or organized delivery system~~ does not provide benefits for a routine physical examination, the carrier ~~or organized delivery system~~ is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement ~~2000 Iowa Acts, Senate File 2126~~ Iowa Code section 514C.19.

ITEM 38. Amend rule **191—73.3(75GA,ch158)**, definition of "Carrier," as follows:

"Carrier" means any entity that provides health benefit plans in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or medical service corporation, a fraternal benefit society, a health maintenance organization, ~~an organized delivery system,~~ and any other entity providing a plan of health insurance or health benefits subject to state regulation.

ITEM 39. Rescind the definition of "Organized delivery system" in rule **191—73.3(75GA,ch158)**.

ITEM 40. Amend rule 191—73.22(75GA,ch158) as follows:

191—73.22(75GA,ch158) Grounds for denial, nonrenewal, suspension or revocation of certificate. The following constitute grounds for denial, nonrenewal, suspension or revocation of the HIPC's certificate following notice and an opportunity for hearing:

1. to 4. No change.

5. Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a person or health care carrier ~~or any organized delivery system~~ otherwise not entitled to the HIPC and that have been entrusted to the HIPC in its fiduciary capacity;

6. and 7. No change.

In addition, the application for certification to be a HIPC may be denied upon a finding by the commissioner that a sufficient number of HIPCs are licensed within a geographic service area and an additional HIPC would adversely affect existing HIPCs.

ITEM 41. Rescind paragraph **74.4(2)"d."**

ITEM 42. Amend rule **191—75.2(513C)**, definition of "Risk load," as follows:

"Risk load" means the percentage above the applicable base premium rate that is charged by a carrier ~~or ODS~~ to an individual to reflect the risk characteristics of such individual.

ITEM 43. Rescind the definition of "Organized delivery system" in rule **191—75.2(513C)**.

ITEM 44. Amend rule 191—75.3(513C) as follows:

191—75.3(513C) Applicability and scope.

75.3(1) and **75.3(2)** No change.

75.3(3) An entity that is not operating as an individual health benefit plan carrier ~~or ODS~~ in this state shall not become subject to the provisions of the Act and this rule solely because an individual that was issued a health benefit plan in another state by that entity becomes a resident of this state.

75.3(4) and **75.3(5)** No change.

ITEM 45. Amend rule 191—75.4(513C) as follows:

191—75.4(513C) Establishment of blocks of business. A carrier ~~or ODS~~ shall file with the commissioner the following information with respect to each established block of business, as defined in Iowa Code section 513C.3.

1. A description of each criterion employed by the carrier ~~or ODS~~ for determining membership in the block of business;

2. and 3. No change.

ITEM 46. Amend rule 191—75.5(513C) as follows:

191—75.5(513C) Transition for assumptions of business from another carrier ~~or ODS~~.

75.5(1) Transfer or assumption of insurance obligation.

a. A carrier ~~or ODS~~ shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering a block of business in this state unless the transaction has been approved by the commissioner of the state of domicile of the ceding carrier ~~or ODS~~.

b. A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk or one or more blocks of business from another carrier ~~or ODS~~ shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of Iowa Code chapter 513C and this chapter.

c. The filing required under paragraph 75.5(1)*"b"* shall:

(1) Describe the block of business, including any eligibility requirements, of the ceding carrier ~~or ODS~~ from which the health benefit plans will be ceded;

(2) Describe whether the assuming carrier ~~or ODS~~ will maintain the assumed health benefit plans as a separate block of business, pursuant to subrule 75.5(3), or will incorporate them into an existing block of business, pursuant to subrule 75.5(4). If the assumed health benefit plans will be incorporated into an existing block of business, the filing shall describe the block of business of the assuming carrier into which the health benefit plans will be incorporated;

(3) to (7) No change.

d. A carrier ~~or ODS~~ required to make a filing under paragraph 75.5(1)*"b"* shall also make an informational filing with the commissioner of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under paragraph 75.5(1)*"b"* and shall include at least the information specified in subparagraph 75.5(1)*"c"*(1) for the individual health benefit plans in that state.

e. A carrier ~~or ODS~~ shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering an individual in this state unless it complies with the following provisions:

(1) The carrier ~~or ODS~~ has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in paragraph 75.5(1)*"c"* for the health benefit plans covering individuals in this state.

(2) If the assumption of a block of business would result in the assuming ~~carrier or ODS~~ carrier's being out of compliance with the limitations related to premium rates contained in Iowa Code section 513C.5, the assuming carrier shall make a filing with the commissioner pursuant to Iowa Code section 513C.5 seeking suspension of the application of Iowa Code section 513C.5.

(3) An assuming carrier ~~or ODS~~ seeking suspension of the application of Iowa Code section 513C.5 shall not complete the assumption of health benefit plans covering individuals unless the commissioner grants the suspension requested pursuant to subparagraph 75.5(1)*"e"*(2).

(4) No change.

75.5(2) Except as provided in subrule 75.5(1), a carrier ~~or ODS~~ shall not cede or assume the entire insurance obligation or risk for a health benefit plan, other than reinsurance, unless the carrier cedes to the assuming carrier the entire block of business that includes such health benefit plan, unless otherwise approved by the commissioner.

75.5(3) The commissioner may approve a longer period of transition upon application of a carrier ~~or ODS~~. The application shall be made within 60 days after the date of assumption of the block of business and shall clearly state the justification for a longer transition period.

75.5(4) Nothing in this rule or in Iowa Code chapter 513C is intended to:

a. Reduce or diminish any legal or contractual obligation or requirements, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier ~~or ODS~~ related to the transaction;

b. Authorize a carrier ~~or ODS~~ that is not admitted to transact the business of insurance in this state to offer health benefit plans in this state; or

c. No change.

ITEM 47. Amend rule 191—75.8(513C) as follows:

191—75.8(513C) Disclosure of information.

75.8(1) General rules. In connection with the offering for sale of a health benefit plan to individuals, each carrier ~~and ODS~~ shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

a. No change.

b. The provisions of such plan concerning the carrier's ~~and ODS's~~ ability to change premium rates and the factors, other than claim experience, which affect changes in premium rates.

c. and *d.* No change.

e. The availability, upon request, of descriptive information about the benefits and premiums available under individual health benefit plans offered by the carrier ~~and ODS~~ for which the individual

is qualified. For purposes of Iowa Code section 513C.7, carriers ~~and ODSs~~ will be permitted to exclude from disclosure of plans those plans within the following categories:

(1) to (4) No change.

75.8(2) Information shall be provided under this rule in a manner determined to be understandable by the average individual and shall be accurate and sufficiently comprehensive to reasonably inform individuals of their rights and obligations under the plan.

Nothing in this rule supersedes the requirements for outlines of coverage for individual health insurance policies under ~~IAC~~ rule 191—36.7(514D).

ITEM 48. Amend rule 191—75.9(513C) as follows:

191—75.9(513C) Standards to ensure fair marketing.

75.9(1) A carrier ~~or ODS~~ shall make available at least one basic and one standard health benefit plan to eligible individuals in this state.

75.9(2) The written information described in this subrule may be provided directly to the individual or delivered through an authorized producer:

a. A carrier ~~or ODS~~ shall not apply more stringent requirements related to the application process for the basic and standard health benefit plans than applied for other health benefit plans offered by the carrier ~~or ODS~~.

b. A carrier ~~or ODS~~ shall supply a price quote for basic or standard plans to an eligible individual upon request.

c. If a carrier ~~or ODS~~ denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial shall be in writing and state with specificity the reasons for the denial subject to any restrictions related to confidentiality of medical information. The denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the carrier ~~or ODS~~ and may be combined with the notification requirements of Iowa Code chapter 514E. The explanation shall include the following information about the basic and standard benefit plans:

(1) to (3) No change.

75.9(3) The carrier ~~or ODS~~ shall not require an individual to join or contribute to any association or group as a condition of being accepted for coverage except, if membership in an association or other group is a requirement for accepting an individual into a particular health benefit plan, a carrier ~~or ODS~~ may apply such requirement.

75.9(4) A carrier ~~or ODS~~ may not require as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.

75.9(5) Carriers ~~and ODSs~~ offering individual or group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513C.

ITEM 49. Amend subrule **75.10(5)**, Iowa Individual Products tables, as follows:

Iowa Individual Products

Hospital Services	MANDATED INDEMNITY/~~ODS~~				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient Outpatient	60%	80%	80%	60%	60% $400/admit	80% $200/admit
Prostheses	60%	80%	80%	60%	60%	80%
DME—including medical supplies	60%	80%	80%	60%	60%	80%
Ambulance—Emergency	60%	80%	80%	60%	60%	80%
Hospice	60%	80%	80%	60%	60%	80%
Home Health and Physician House Calls	60%	80%	80%	60%	60%	80%

Alcoholism Substance Abuse	MANDATED INDEMNITY/~~ODS~~				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient	—	80%(1)	80%(1)	60%(1)	—	80%
Outpatient	—	80%(1) ($50 max. eligible fee)	80%(1)	60%(1)	—	80% ($50 max. eligible fee)

Mental Health	MANDATED INDEMNITY/~~ODS~~				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Inpatient	—	80%(1)	80%(1)	60%(1)	—	80%
Outpatient	—	80%(1) ($50 max. eligible fee)	80%(1) ($50 max. eligible fee)	60%(1) ($50 max. eligible fee)	—	80% ($50 max. eligible fee)

(1)$50,000 Lifetime Max.

Iowa Individual Products

General	MANDATED INDEMNITY/~~ODS~~				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Calendar year deductibles (S/F)	$1,500 x 3	$1,000 x 3	$1,000 x 3	$1,000 x 3	—	—
E.R. Copayment	—	—	—	—	$50 (waived if admitted)	$50 (waived if admitted)
Coinsurance	60%	80%	80%	60%	60%	80%
Annual out-of-pocket max.(1)	$4,800/ $14,400	$2,000/ $4,000	$2,000/ $4,000	$3,000/ $6,000	$4,000/ $8,000	$2,000/ $4,000
Lifetime Maximum	$250,000	$1,000,000	$1,000,000	$1,000,000	$250,000	$1,000,000
Pre-existing	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)	513C.7(4) (a)&(b)
Rx	60%	80%	80%	60%	Copayment of > $30 or 25%	Copayment of > $20 or 25%
Transplants	None	80%	80%	80%	None	80%

(1)Excludes deductibles and copays

Physician Services	MANDATED INDEMNITY/~~ODS~~				MANDATED HMO	
			PPO			
	BASIC	STANDARD	In	Out	BASIC	STANDARD
Office visits including wellness	60%	80%	$20 copay 100%	$40 copay 60%	$20 copay per office visit	$15 copay per office visit
Urgent Care	60%	80%	80%	60%	60%	80%
Inpatient	60%	80%	80%	60%	60%	80%
Outpatient	60%	80%	80%	60%	60%	80%

ITEM 50. Amend rule 191—75.11(513C) as follows:

191—75.11(513C) Maternity benefit rider. Every individual insurance carrier ~~and ODS~~ shall offer an optional maternity benefit rider for the basic and standard health benefit plans providing benefits, as any other illness, for a pregnancy and delivery without complications with a 12-month waiting period. Credit toward meeting the waiting period shall be given for prior coverage of a pregnancy without complications provided there was no more than a 63-day break in coverage. A maternity rider offered under this rule shall only be offered when the basic or standard plan is initially purchased. Premiums for the rider shall be calculated based upon generally accepted actuarial principles and shall not be subject to the premium restrictions in Iowa Code subsection 513C.10(6). The earned premiums and paid losses associated with the rider shall not be considered by the Iowa Individual Health Benefit Reinsurance Association for purposes of Iowa Code section 513C.10.

ITEM 51. Amend rule 191—75.12(513C) as follows:

191—75.12(513C) Disclosure requirements. All carriers ~~and ODSs~~ shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier ~~or ODS~~ offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers ~~and ODSs~~ shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

ITEM 52. Amend rule 191—75.17(513C) as follows:

191—75.17(513C) Reconstructive surgery.

75.17(1) A carrier ~~or organized delivery system~~ that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. to *c.* No change.

75.17(2) and **75.17(3)** No change.

75.17(4) A carrier ~~or organized delivery system~~ shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier ~~or organized delivery system~~ shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

ITEM 53. Amend rule 191—75.18(514C) as follows:

191—75.18(514C) Contraceptive coverage.

75.18(1) A carrier ~~or organized delivery system~~ that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

75.18(2) A carrier ~~or organized delivery system~~ is not required to offer benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

75.18(3) No change.

75.18(4) A carrier ~~or organized delivery system~~ shall make available benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

75.18(5) If a carrier ~~or organized delivery system~~ does not provide benefits for a routine physical examination, the carrier ~~or organized delivery system~~ is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement ~~2000 Iowa Acts, Senate File 2126~~ Iowa Code chapter 514C.

ITEM 54. Amend rule **191—78.2(514L)**, definition of "Provider of third-party payment or prepayment of prescription drug expenses," as follows:

"Provider of third-party payment or prepayment of prescription drug expenses" or *"provider"* means a provider of an individual or group policy of accident or health insurance or an individual or group hospital or health care service contract issued pursuant to Iowa Code chapter 509, 514 or 514A, a provider of a plan established pursuant to Iowa Code chapter 509A for public employees, a provider of an individual or group health maintenance organization contract issued and regulated under Iowa Code chapter 514B, ~~a provider of an organized delivery system contract regulated under rules adopted by the director of public health,~~ a provider of a preferred provider contract issued pursuant to Iowa Code chapter 514F, a provider of a self-insured multiple employer welfare

arrangement, and any other entity providing health insurance or health benefits which provide for payment or prepayment of prescription drug expenses coverage subject to state insurance regulation.

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